U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 15 May 2007

In the Matter of

H.J.L.,
Claimant,

CASE NO.: 2005-BLA-5576

v.

SHANNON POCAHONTAS MINING COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

W. Andrew Delph, Jr., Esquire
For the Claimant

Karin L. Weingart, Esquire
For the Employer

Before: Edward Terhune Miller
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

Statement of the Case

This proceeding involves a claim for benefits filed by H.J.L., a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations (CFR).[1]

[1] All regulations referred to by section or part are contained in Title 20, CFR, unless otherwise indicated. The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on December 6, 2005, in Princeton, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and regulations. The evidentiary record consists of the hearing transcript, Director's Exhibits 1 through 78 (DX 1-78), and Claimant's Exhibits 1 through 7 (CX 1-7). The filing deadline for written closing argument was extended to March 15, 2006. The findings of fact and conclusions of law which follow are based upon analysis of the pertinent record, including documentary evidence, testimony, and arguments, with pertinent credibility determinations.

Procedural History

Claimant, H.J.L., filed his initial application for Federal black lung benefits on July 8, 1992 (DX 1). Following a formal hearing, Administrative Law Judge Glenn Robert Lawrence denied benefits by order dated September 23, 1993 (DX 1). That denial became final (DX 1, 77).

On January 23, 1996, Claimant filed the current application for black lung benefits under the Act (DX 2), which was initially granted by the District Director's office on July 18, 1996 (DX 29) and October 21, 1996 (DX 37). Following Employer's timely controversion (DX 28, 38), this claim was forwarded to the Office of Administrative Law Judges (OALJ) on December 23, 1996 (DX 40). On October 3, 1997, Administrative Law Judge Pamela Lakes Wood remanded the case to the District Director for further investigation related to identification of the responsible operator (DX 45).

After the District Director determined on August 22, 2003, that other coal mine companies, Little Eagle, Inc. and Thomas Carl Coal Co., Inc. are not the putative responsible operators in this claim, it returned the case to OALJ on December 8, 2003 (DX 57, 60). On April 19, 2004, Administrative Law Judge Linda S. Chapman remanded the case again to the Director so that Claimant could be provided with an updated pulmonary examination, and for further development related to the putative responsible operator. (DX 68).

After the pulmonary evaluation and further investigation of the responsible operator the District Director redesignated Shannon Pocahontas Mining Company as the putative responsible operator by a Proposed Decision and Order on Remand dated January 6, 2006. The District Director reversed its decision from an award to a denial of benefits (DX 72), and by letter dated

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Part 725 regulations, however, were to apply only to clams filed on or after January 19, 2001, *not* to pending cases. The current, duplicate claim was filed on January 22, 1996 (DX 2). §725.309(2001) and §725.414(2001). §725.2. Whether there has been a "material change in conditions" is governed by §725.309 of the pre-amendment regulations, and the evidentiary limitations in §725.414 of the amended regulations are not applicable (TR 6-8; *compare* DX 78).

January 6, 2005, sought reimbursement from Claimant of an overpayment totaling $73,239.30 (DX 73). Under cover letter dated January 24, 2005, Claimant filed an "Overpayment Recovery Questionnaire" seeking a waiver of the overpayment (DX 74). On February 7, 2005, the case was returned to OALJ for adjudication (DX 75-78). [2]

Issues

I. Whether the miner is totally disabled?
II. Whether the miner's disability, if proved, is due to pneumoconiosis?
III. Whether the evidence establishes a material change in conditions pursuant to § 725.309?[3]

(DX 75, as amended; TR 10-12).

Findings of Fact

I. Background

A. Coal Miner Status and Length of Coal Mine Employment

Claimant alleges that he worked as a coal miner for 23 years ending in 1989, when the mines ceased operations (DX 1, 2; TR 16). The parties stipulated that Claimant engaged in coal mine employment for *at least* 19 years, which is supported by the record. (TR 11-12).

B. Date of Filing

Claimant filed his current claim on January 22, 1996 (DX 2). There is no evidence which rebuts the presumption of timeliness. § 725.308(c).

C. Dependents

As of the January 22, 1996, filing date Claimant claimed his wife, Pauline, and his son, Donald as dependents for the purpose of possible augmentation for benefits. His son was born on July 5, 1974, but was still attending school (DX 2). The son's dependency ended when he

[2] The District Director was not represented at the formal hearing; the overpayment issue was marked as contested under "Other Issues" on the Form CM-1025 transmittal sheet (DX 75), although that document expressly records no certification of payment by the Trust Fund. There is also no evidence that the Director made any determination after Claimant's submission. Neither party represented at the hearing addressed the issue, and there was no testimony relating to it. Although Claimant's protest letter and attachments are in evidence, the issue was not litigated before this tribunal, and, therefore, has not been addressed. A waiver should not be imputed to the Director under these circumstances. The matter, however, should now be ripe for appropriate action by the Director.

[3] Although "Subsequent Claims relating to material change in conditions was controverted on the Form CM-1025 (DX 75), Employer narrowed the contested issues at the hearing to "total disability" and "causation" (TR 10). Since Judge Lawrence's denial of the prior claim dated September 23, 1993, was based upon Claimant's failure to establish the presence of a totally disabling respiratory impairment (DX 1), which is contested, Claimant must initially establish a "material change in conditions."

ceased being a full-time student or when he reached the age of 23, whichever occurred first. The Employer did not contest dependency (TR 16).

D. Responsible Operator

Employer abandoned controversion of its designation as responsible operator (TR 10). Although Employer, Shannon Pocahontas Mining Company, was not the last coal mine company for whom Claimant worked at least one calendar year, the Director found that Claimant's subsequent employers are no longer in business and were not insured, so that Shannon Pocahontas Mining Company is the properly designated responsible operator under the Act and applicable regulations (DX 1, 57, 71, 72).

E. Personal, Employment, and Smoking Histories

Claimant was born on October 20, 1945; he has an 8th grade education (DX 1, 2). Claimant testified that he last worked as a roof bolter (TR 17; DX 1, 7/22/93-Hearing TR 12) which involved working in 28 to 32 inches coal. Claimant used 5 foot bolts, and had to put them on the ground to bend them. Claimant would push the bolts in the hole and operate the drill into the overhead from his knees. Claimant stated that the job was not easy, and that it entailed considerable dust exposure (TR 17-20, 23).

The record also contains a very extensive Vocational Assessment dated July 13, 1993, conducted by Laura J. Patterson, a Licensed Professional Counselor (DX 1), which establishes that the position of Roof Bolter entails "Medium work" (DX 1). Judge Lawrence found that Claimant's last usual coal mine job involved "medium labor." (DX 1, ALJ Lawrence, Decision and Order, p. 5).

Claimant testified that when he tries to do something, he "can't breathe a lick." He complained of breathing problems on minimal exertion, such as walking "25" on a level ground, or climbing 3 or 4 steps. He testified that Dr. Patel has treated him for his breathing condition for years, and prescribed a couple of inhalers and breathing pills (TR 20-21). In addition to his breathing difficulties, Claimant testified that he has numerous other physical problems relative to back surgery in or about 1982, when a disc was removed, his neck, both knees, his right shoulder, and his right elbow, which he related to his work as a roof bolter in low coal (TR 23-24). Claimant's work in low coal was obviously difficult and injurious from an orthopedic standpoint, having caused several injuries, but his duties as a roof bolter involved medium labor from a pulmonary or respiratory standpoint.

Claimant testified that he smoked "[a]bout a pack a day – sometimes half," cigarettes from age 17 in 1962 to 1988. (TR 21-22). Dr. Jabour reported a cigarette smoking history of 1 pack per day from 1962 to 1988 (DX 15, Sec. C3). Dr. Forehand listed a smoking history of 1 pack per day from age 16 to 1988 (DX 69, Sec. C3). Thus, Claimant has a cigarette smoking history of approximately 1 pack per day for 26 or 27 years ending in 1988.

II. New Medical Evidence

A. Chest X-rays

Employer does not contest the presence of pneumoconiosis (TR 10). There is no evidence of *complicated* pneumoconiosis, and so the x-ray evidence establishes that Claimant has clinical, *simple* pneumoconiosis (DX 18, 19, 46, 47, CX 1-7; *compare* DX 69)

B. Pulmonary Function Studies

A claimant must prove that he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis under the applicable regulatory criteria. The record contains the results of pulmonary function studies dated March 26, 1996 (DX 14), October 8, 1997 (DX 47), May 5, 2004 (DX 69), and June 14, 2005 (CX 1), none of which are qualifying under Part 718, Appendix B, and which do not establish a totally disabling pulmonary or respiratory impairment.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange, which will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The record includes the results of arterial blood gas studies administered on March 26, 1996 (resting and exercise) (DX 16);[4] October 8, 1997 (resting only) (DX 47);[5] and, May 5, 2004 (resting and exercise)(DX 69). Only the resting blood gas test dated March 26, 1996, is qualifying under Part 718, Appendix C. The more recent resting blood gas studies dated October 8, 1997 and May 5, 2004, are not qualifying. Neither exercise blood gas study is qualifying, and so the preponderance of the arterial blood gas evidence is nonqualifying, and does not establish a totally disabling pulmonary or respiratory impairment.

D. Physicians' Opinions

CT Scan Interpretations

The record includes recent chest CT scan interpretations by Drs. Church and Bofill, who are physicians at Welch Community Hospital (CX 1). The CT scans were conducted on December 17, 2003, August 23, 2004, and October 11, 2005. On the CT scan dated December 17, 2003, Dr. Jack L. Church found "hyperlucency in both lung fields and some chronic appearing interstitial disease, particularly in the upper lobes." (CX 1, p. A9). On the CT scan dated August 23, 2004, Dr. Rano S. Bofill stated, in pertinent part:

[4] Dr. Ranavaya completed a U.S. Department of Labor (DOL) validation form dated April 30, 1996 (DX 17). Dr. Ranavaya placed a checkmark next to the word "Yes," indicating that he found the March 26, 1996, blood gas test to be technically acceptable (DX 17). However, the form does not contain any rationale for Dr. Ranavaya's validation, or specify which of the blood gas studies were reviewed, or the test results. Consequently, the validation is accorded little weight.

[5] In his report dated August 27, 1998, Dr. Crisalli recorded that an exercise blood gas study was not performed because of Claimant's back pain. (DX 49).

There is suggestion of emphysema and chronic interstitial changes. Lung window shows nodular densities in the right, which is probably benign; however, a follow up study in four to six months is suggested for stability. There is no gross consolidation, atelectasis, pleural effusion, or pneumothorax. It has to be mentioned that some of the nodules appear to be somewhat speculated and neoplasm cannot entirely be ruled out…

IMPRESSION: Chronic lung changes as described. Multiple nodules on the right lung as described and follow up study in four to six months is suggested. No active disease.

(CX 1, p. A8).

On the CT scan dated October 11, 2005, Dr. Bofill recorded:

Study compared with August 23, 2004.

…There is no gross consolidation, atelectasis, pleural effusion or pneumothorax. Chronic obstructive pulmonary disease is suggested. Multiple nodules are again noted, which most likely are granulomatous. Again some nodules on the right upper lung appear to be somewhat speculated although this could be due to overlapping. However, follow up in one year is suggested for stability…

IMPRESSION: Chronic changes as described. No active consolidation. Follow up study in one year for stability.

(CX 1, p. A10).

Thus, the CT scans disclose various abnormalities, but do not specifically diagnose pneumoconiosis. Since CT scans and x-rays are diagnostic of disease, but do not measure functional impairment, the more relevant medical opinion evidence includes the post-final denial reports of Drs. Jabour (DX 15), Crisalli (DX 49), Patel (DX 65; CX 1), and Forehand (DX 69), particularly regarding "total disability" and "causation."

Dr. E. Rhett Jabour

Dr. Jabour, who is board-certified in internal medicine and the subspecialty of pulmonary disease, examined Claimant on March 26, 1996 (DX 15).[6] On a DOL form, Dr. Jabour noted Claimant's coal mine employment history from 1967 to 1989, most recently as a roof bolter (DX 15, Sec. B), and family, medical, and social histories. Dr. Jabour also reported Claimant's complaints of numerous respiratory or pulmonary-related problems (DX 15, Sec. D1), although his findings on physical examination of the thorax and lungs were "Normal" or "Clear" (DX 15,

[6] Judicial notice has been taken of the professional qualifications of physicians which are not otherwise of record by reference to the B-reader List published at the website of the Office of Administrative Law Judges at http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm and the American Board of Medical Specialties at www.abms.org. *See Maddaleni v. Pittsburg & Midway Coal Co.*, 14 BLR 1-135 (1990).

Sec. D4). In addition, Dr. Jabour conducted various clinical studies. Under the "Summary of Results" section of the form report, Dr. Jabour stated, in pertinent part:

Chest X-ray:	Simple pneumoconiosis cat. p/r 1/1
Vent Study (PFS)	FEV1 83% DLCO 74%
	FVC 110% MVV 61%
Arterial Blood Gas	Resting…PCO2 29 PO2 66
	Exercise PCO2 30 PO2 84
Other: EKG	Normal Sinus Rhythm

(DX 15, Sec. D5).

In a typewritten attachment to the form report, Dr. Jabour set forth the following cardiopulmonary diagnoses: 1. Pneumoconiosis and, 2. Obstructive airways disease. Dr. Jabour explained that the diagnosis of pneumoconiosis was based upon the x-ray evidence, but did not specify the basis for the diagnosis. Although Dr. Jabour listed "coal dust exposure and silica dust exposure" as the etiology of Claimant's pneumoconiosis, he related the obstructive airways disease to "airways hyper-activity." Finally, he described the severity of Claimant's impairment as follows:

> Degree of respiratory impairment is 35% based on MVV. The impairment is total based on musculoskeletal back disease. The diagnosis D6 (*i.e.,* pneumoconiosis and/or obstructive airways disease) contributes to the impairment by 25%. The non cardiopulmonary diagnosis is low back disease, low back degenerative disc disease.
>
> (DX 15).

Dr. Robert J. Crisalli

Dr. Robert J. Crisalli, who is board-certified in Internal Medicine and Pulmonary Diseases, examined Claimant on October 8, 1997 (DX 49). Dr. Crisalli issued a "History and Physical" report, and a supplemental report dated August 27, 1998 (DX 49), which set forth Claimant's complaints of chronic productive cough, and a coal mine employment history from 1967 to 1989, primarily as a roof bolter and miner operator. Dr. Crisalli understated Claimant's cigarette smoking history as one pack per day for 20 years ending in 1988, and set forth Claimant's medical history, medications, review of systems, physical examination, and the results obtained on various clinical tests, which included a positive (1/1) chest x-ray reading; pulmonary function studies indicative of "mild" obstruction, air trapping, and diffusion defect, with "significant improvement" in the FEV1 after bronchodilation; and, a "normal" resting blood gas study. Dr. Crisalli reviewed other medical data, including the opinion and clinical findings of Dr. Jabour, as well as some older x-ray data, which was negative for pneumoconiosis.

Although Dr. Crisalli acknowledged that "the more recent x-ray readings suggest the presence of coal worker's pneumoconiosis," he surmised that, in view of other data, the changes were actually "old granulomatous disease" (DX 49, p. 4). His finding of

granulomatous disease is consistent with the most recent CT scan interpretation (CX 1, p. A10). Since the existence of pneumoconiosis is not in issue, Dr. Crisalli's opinion is primarily material to "total disability," as to which Dr. Crisalli concluded:

In summary, [Claimant] has chronic bronchitis secondary to his heavy tobacco smoke exposure history. His pulmonary impairment is minimal and, he is not limited from performing very heavy manual labor from the standpoint of his pulmonary function. Though [Claimant] complains of dyspnea with just walking around his house, it is clear that this dyspnea is not related in any way to pulmonary functional impairment since [Claimant's] impairment is only minimal. [Claimant] may well be disabled on the basis of his back problems.

[Claimant's] chronic bronchitis is secondary to his tobacco smoke exposure and has not been aggravated by or contributed to in any significant way by his coal dust exposure. [Claimant] retains the pulmonary functional capacity to perform very heavy manual labor.

(DX 49, pp. 4-5).

Dr. Vishnu A. Patel

Dr. Patel, who is board-certified in Internal Medicine, Pulmonary Disease, Critical Care Medicine, and Sleep Disorders, issued a cursory, "To Whom It May Concern" report dated March 4, 2003 (DX 65), as follows:

Please be advised that [Claimant] is our patient that carries the diagnoses of pneumoconiosis and asthma with daily dyspnea and chronic hypoxemia interrupting his daily activities and decreasing his functional mobility. This is a chronic respiratory disorder not likely to improve over time. He is on pulmonary medications including Uniphyl, Flovent and Albuterol which he will need for an indefinite period of time. He also has required corticosteroid for quite some time with recent discontinuation. We are monitoring his progress carefully. He does suffer from frequent respiratory infections requiring antibiotics. Spirometry was recently performed which showed reduced FEV1. Chest x-ray has revealed bilateral interstitial disease with essentially no interval change. He reports over 20 years of working in the coal mines and also suffered trauma during that time as well. You may review his medical records from our office for further review.

If you need any further assistance regarding this patient or have any questions please feel free to contact our office.

(DX 65).[7]

On June 14, 2005, Dr. Patel issued a report which listed "COPD, dyspnea and pneumoconiosis" as Claimant's chief complaints (CX 1, p. A12). Under "HPI," Dr. Patel stated:

[7] The clinical data referenced in this March 4, 2003, report are not in evidence.

[Claimant] has above diagnoses. Denies chest pain, palpitations, fever or chills. He occasionally has a cough without any expectorations. No trouble with swallowing or choking. No hemoptysis. No dizziness or diaphoresis. He does have significant dyspnea at times. No tingling or numbness. No abdominal pain. He continues to have a lower back pain and arthritis.

(CX 1, p. A12). On physical exam, Dr. Patel noted that Claimant "appears to be in no respiratory distress." On chest examination, Dr. Patel stated: "Bilateral decreased air entry without crackles or wheezing. Bilateral chest expansion." Pulse Ox yielded "97% saturations on room air by finger probe." Dr. Patel also reported that an "ABG was done recently which showed PCO2 74."[8] In conclusion, Dr. Patel set forth the following "Assessment and Plan:"

(1) Coal worker's pneumoconiosis appears mild to moderate in nature. No evidence of CHF or pneumonia. Continue current medications. He should get a flu shot every year. He is currently on Advair and Albuterol which he needs to use all the time.
(2) Arthritis and lower back pain. Continue Lodine and Lortab as prescribed.

Reassess in 3 months or earlier if needed.

(CX 1, p. A12).

Dr. Patel also issued a cursory, supplemental report dated September 26, 2005 (CX 1, p. A1), as follows:

Please be advised that [Claimant] is our patient and carries the diagnosis of pneumoconiosis with current hypoxemia. He is totally and permanently disabled due to his underlying respiratory condition. He does exhibit shortness of breath on minimal exertion and chronic cough. Complete PFT in the past has been abnormal as well as multiple lung nodules appearing on CT of chest. He does need repeat imaging done at this time to ensure no interval increase. He will require life long use of respiratory medications and routine follow up in our office to help prevent deterioration of his condition.

If you have any questions regarding this patient please feel free to contact me.

(CX 1, p. A1).[9]

[8] The most recent arterial blood gas study in evidence was administered by Dr. Forehand on May 5, 2004. The resting blood gas test yielded a PCO2 of 74 (DX 69). Therefore, it appears that Dr. Patel referred to the May 5, 2004, resting blood gas test, Dr. Patel's report dated June 14, 2005, does not mention any other laboratory results, even though he conducted pulmonary function studies on that date (CX 1, p. A12; *See* CX 1, pp. A3-A7).

[9] Although Dr. Patel did not specify the date of the "PFT in the past," he conducted a pulmonary function study on June 14, 2005 (CX 1, pp. A3-A7).

Dr. J. Randolph Forehand

Dr. Forehand, who is a B-reader, who is board-certified in Pediatrics and Allergy & Immunology, and board-eligible in Pediatric Pulmonary Medicine, examined Claimant on May 5, 2004 (DX 69). Dr. Forehand is. Dr. Forehand's curriculum vitae indicates extensive experience with pulmonary diseases, including pneumoconiosis and asthma, though he is not a board-certified pulmonary specialist (DX 69).

On a DOL form dated May 5, 2004, Dr. Forehand recorded Claimant's coal mine employment history from 1970 to 1989 (DX 169 Sec. B), and family, medical, and social histories. He reported Claimant's complaints of sputum, wheezing, dyspnea, cough, orthopnea, ankle edema, and paroxysmal nocturnal dyspnea (DX 69, Sec. D1), but normal physical findings on examination of the thorax and lungs (DX 69, Sec. D4). Dr. Forehand summarized the results of various clinical tests which he conducted on May 5, 2004, as follows:

Chest X-ray	no coal workers' pneumoconiosis; R/O pulmonary mass[10]
Vent Study (PFS)	normal ventilatory pattern
Arterial Blood Gas	no arterial hypoxemia
Other: EKG	normal tracing

(DX 69, Sec. D5).

Under the Cardiopulmonary Diagnosis section of the form report, Dr. Forehand stated: "no evidence of coal workers' pneumoconiosis, R/O pulmonary mass" (DX 69, Sec. D6). Regarding the severity of Claimant's impairment due to chronic respiratory or pulmonary disease, Dr. Forehand opined: "No respiratory impairment." (DX 69, Sec. D8a), but noted that Claimant should be referred to another physician for further evaluation by CT scan of the chest (DX 69; Sec. E).

Conclusions of law and Discussion

III. Material Change in Conditions Under § 725.309

Under the applicable § 725.309(d), if a prior miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless there has been a material change in conditions or the later claim is a request for modification. Since the prior claim was finally denied on September 23, 1993 (DX 1), and Claimant's current application for benefits was filed more than one year after the denial (DX 2), the current claim is a duplicate or additional claim, *not* a modification request under §725.310, and requires a threshold determination as to whether the evidence submitted since the prior denial is sufficient to establish a material change in conditions pursuant to § 725.309(d).

[10]Although Dr. Forehand interpreted the chest x-ray dated May 5, 2004, as negative for coal worker's pneumoconiosis, he noted the following abnormalities on the x-ray form under Other Comments: "irregular opacities upper lobes bilaterally, ? hilar lymphadenopathy, R/O malignancy, R/O infection" (DX 69). However, the more relevant portion of Dr. Forehand's opinion relates to "total disability."

As Claimant last engaged in coal mine employment in West Virginia (DX 3), the law of the United States Court of Appeals for the Fourth Circuit applies. *Shupe v. Director, OWCP,* 12 BLR 1-200 (1989)(en banc). The applicable standard for determining whether a material change has occurred in the Fourth Circuit was set forth in *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd*, 86 F.3d 1358 (4th Cir. 1996)(en banc), *cert. denied*, 117 S.Ct. 763 (1997); see also *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994). Under this standard, all of the new evidence, favorable and unfavorable, must be considered to determine whether the miner has proved at least one of the elements of entitlement previously adjudicated against him. If the miner establishes
the existence of such an element, he has proved, as a matter of law, a material change in conditions, which requires a *de novo* review of the entire record. Since the final denial of the prior claim was based upon Claimant's failure to establish the element of "total disability" and, incidentally, "causation" by pneumoconiosis, Claimant can only establish a material change in conditions under § 725.309, if the new evidence, favorable and unfavorable, proves that he now suffers from a totally disabling pulmonary or respiratory impairment.

Pneumoconiosis

Employer does not contest the existence of pneumoconiosis (TR 10). Evidence of record is sufficient to sustain such a finding, and, accordingly, Claimant has established the existence of pneumoconiosis under § 718.202(a). However, the finding of simple pneumoconiosis does not establish a material change in conditions under § 725.309, because the existence of pneumoconiosis was not an element of entitlement upon which the prior claim was finally denied (DX 1- Decision and Order dated Sept. 23, 1993).

Causal Relationship

Since Claimant has established the presence of pneumoconiosis, he is entitled to invoke the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. § 718.203. Cause is not in issue, and the presumption has not been rebutted. (TR 10). However, a material change in conditions is not established under § 725.309, because "causal relationship" was not an element of entitlement upon which the prior claim was finally denied. (DX 1- Decision and Order dated September 23, 1993).

Total Disability

A claimant can establish total disability by proving that the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. § 718.204(b)(1). Since complicated pneumoconiosis is not in issue, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's

respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. § 718.204(b)(2)(i)-(iv).

None of the recent pulmonary function studies are qualifying under Part 718, Appendix B, and so total disability is not established pursuant to § 718.204(b)(2)(i). Only the resting arterial blood gas test dated March 26, 1996, is qualifying under Part 718, Appendix C. The more recent resting blood gas studies dated October 8, 1997, and May 5, 2004, are not qualifying. Neither of the exercise blood gas studies is qualifying. Therefore, since the preponderance of the arterial blood gas evidence is nonqualifying, total disability has not been established pursuant to § 718.204(b)(2)(ii). There is no evidence of cor pulmonale with right-sided heart failure, so that total disability has not been established pursuant to § 718.204(b)(2)(iii).

The relevant medical opinions are those of Drs. Jabour (DX 15), Crisalli (DX 49), Patel (DX 65; CX 1), and Forehand (DX 69), regarding the existence of total disability and whether it was caused by pneumoconiosis. The credibility of the medical opinions in evidence has been assessed by analyzing the credibility of each medical opinion considered as a whole, in light of physicians' credentials, documentation, and reasoning. Drs. Crisalli, Jabour, and Patel are board-certified pulmonary specialists. Dr. Patel has treated Claimant for several years. Dr. Forehand lacks board-certification, but has significant experience, in pulmonary medicine. However, factors other than credentials are more significant in weighing the relative merits of medical opinions evidence, as discussed below.

In 1996, Dr. Jabour assessed Claimant's respiratory impairment as 35%. Furthermore, Dr. Jabour found that Claimant is totally disabled from musculoskeletal back disease, but did not specify whether Claimant was totally disabled from a pulmonary or respiratory standpoint alone. Since the qualifying results obtained on the 1996 resting blood gas study are questionable in light of the subsequent nonqualifying blood gas studies at rest and exercise, Dr. Jabour's opinion is accorded little weight.

In 1997 Dr. Crisalli provided a pulmonary evaluation of Claimant in conjunction with his review of specified prior medical data, and found that Claimant suffered from "minimal" pulmonary function impairment, which Dr. Crisalli attributed to tobacco smoke exposure. Although Dr. Crisalli agreed that Claimant "may well be disabled on the basis of his back problems," he opined that Claimant "retains the pulmonary functional capacity to perform very heavy manual labor." Dr. Crisalli's pulmonary assessment is deemed to be consistent with the "mild" impairment shown on pre-bronchodilator pulmonary function testing with "significant improvement in FEV1" post-bronchodilator, and the "normal" resting blood gas test. Accordingly, Dr. Crisalli's opinion is reasoned and documented, though based upon old medical data. Therefore, it simply establishes that Claimant did not suffer from a totally disabling pulmonary or respiratory impairment in 1997.

> Dr. Patel issued reports dated March 4, 2003 (DX 65), June 14, 2005 (CX 1, p. A 12), and September 26, 2005 (CX 1, p. A1). In his March 3, 2003, report Dr. Patel stated that Claimant "carries the diagnoses of pneumoconiosis and asthma with daily dyspnea and chronic hypoxemia interrupting his daily activities and decreasing his functional

mobility," but did not directly address total disability. In his June 14, 2005, Dr. Patel did not mention asthma, but reported diagnoses of COPD, dyspnea, and pneumoconiosis, and, again, did not directly address total disability. He described Claimant's pneumoconiosis as "mild to moderate in nature." In the report dated September 26, 2005, Dr. Patel mentioned neither asthma nor COPD, but simply stated that Claimant "carries the diagnosis of pneumoconiosis with current hypoxemia." He also stated that Claimant is "totally and permanently disabled due to his underlying respiratory condition." However, Dr. Patel's reports lack specificity regarding the underlying bases for his conclusions. He did not mention the dates upon which the clinical data were obtained. He did not explain why he excluded "asthma" and "COPD" from his listed diagnoses, and did not mention Claimant's extensive cigarette smoking history. His finding of total and permanent respiratory disability is inconsistent with the variability shown in the pertinent test results, and the essentially normal pulmonary function studies and arterial blood gases obtained in 2004, approximately 15 years after Claimant left the coal mines. As a result Dr. Patel's opinion is accorded little weight.

In 2004 Dr. Forehand conducted a pulmonary evaluation of Claimant, and found "no respiratory impairment." Although Dr. Forehand's analysis was somewhat cursory, his opinion is consistent with the normal physical findings, and the essentially normal results obtained on the pulmonary function and arterial blood gas studies which he conducted.

The opinions of Drs. Jabour and Crisalli are based upon medical data obtained in 1996 and 1997, respectively. Dr. Crisalli's opinion, which establishes that Claimant was not totally disabled by a pulmonary or respiratory impairment, has greater credibility. However, in view of the significant gap in time, and the progressive, irreversible, and latent nature of pneumoconiosis, Dr. Crisalli's 1997 opinion does not preclude a subsequent finding of total disability. The medical opinions of Drs. Patel and Forehand are significantly more recent. Dr. Patel ultimately found that Claimant suffers from a total and permanent respiratory impairment, but in an opinion that was neither well-reasoned nor well-documented. Therefore, regardless of Dr. Forehand's contrary opinion, Claimant has not established total pulmonary or respiratory disability. Dr. Forehand's opinion regarding total disability is more consistent with the credible, objective medical data, which are nonqualifying. Thus, the reasoned medical opinion evidence does not establish the presence of a totally disabling pulmonary or respiratory impairment, and Claimant has not established total disability pursuant to § 718.204(b)(2)(iv), or otherwise. Since Claimant has not established that he suffers from a total pulmonary or respiratory disability, he cannot establish total disability due to pneumoconiosis as defined in § 718.204(c). Accordingly, Claimant has not established a material change in conditions under § 725.309. Consequently, Claimant is not eligible for black lung benefits under the Act and regulations.

ORDER

The claim of H.J.L. for benefits under the Black Lung Benefits Act is denied**.**

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Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).